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The Addiction Technology Transfer Center Network
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# Rural Regions

# And

# Substance Abuse

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# Rural Regions and Substance Abuse

The rural environment of the United States has moved beyond the historically accepted concept of small communities, with close-knit families, and a self-supporting agriculturally based economy. The reality of today's rural population is that many of these communities are encountering the same substance abuse issues as the inhabitants of the more crowded urban/metropolitan communities. In some cases, the social problems of those living in sparsely populated areas have actually exceeded those of their urban counter-parts. Often times this is due to significantly challenging characteristics of their physical and social environment. Today, there are equal opportunities to obtain and use drugs in both urban and rural communities.

This report examines the prevalence of substance abuse within rural American communities, utilizing data gathered from various nationally recognized surveys on substance abuse and the social and economical issues associated with life in a rural community. Comparisons will be drawn between available New England regional data and that from across the nation. Before looking at some of the specific issues related to rural substance abuse we need to see how these areas are defined.

## Definition of Areas of Population

There are many definitions of urban and rural. Rural can be used to define a state, or the condition of a person or place. Rural can be examined in the context of economic, social, cultural, and psychological impact. Depending upon the study, both rural and urban areas can be defined as metropolitan or non-metropolitan. This lack of firm delineation leads to some important points to consider, when we examine sources for data regarding urban and rural areas. The United States Department of Commerce, Bureau of the Census provides one definition of rural and urban communities and further describes whether either is metropolitan or non-metropolitan.

***Urban*:** All territory, population and housing units in urbanized areas and urban clusters. "Urban" classification cuts across other hierarchies and can be in metropolitan or non-metropolitan areas.

***Urban Area*:** Collective term referring to all areas that are urban. For Census 2000, there are two types of urban areas: urban clusters and urbanized areas.

***Urban Cluster (UC):*** A densely settled territory that has at least 2,500 people but fewer than 50,000.

***Urbanized Area (UA):*** An area consisting of a central place(s) and adjacent territory with a general population density of at least 1,000 people per square mile of land area that together have a minimum residential population of at least 50,000 people. The US Bureau of the Census uses published criteria to determine the qualification and boundaries of UAs.

***Rural:*** Rural is defined as, territory, population and housing units not classified as urban. "Rural" classification cuts across other hierarchies and can be in metropolitan or non-metropolitan areas.

***Metropolitan***: Metropolitan refers to those areas surrounding large and densely populated cities or towns.

***Metropolitan area (MA):*** A collective term, established by the federal Office of Management and Budget, to refer to metropolitan statistical areas, consolidated metropolitan statistical areas, and

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primary metropolitan statistical areas.

***Metropolitan statistical area (MSA):*** A geographic entity defined by the federal Office of Management and Budget (OMB), for use by federal statistical agencies, based on the concept of a core area with a large population nucleus, plus adjacent communities having a high degree of economic and social integration with that core. Qualifications of an MSA requires the presence of a city with 50,000 or more inhabitants, or the presence of an Urbanized Area (UA) and a total population of at least 100,000 (75,000 in New England). The county or counties containing the largest city and surrounding densely settled territories are central counties of the MSA. Additional outlying counties qualify to be included in the MSA by meeting certain other criteria of metropolitan character, such as a specified minimum population density or percentage of the population that is urban. *MSAs in New England are defined in terms of minor civil divisions, following rules concerning commuting and population density*.

These definitions provide a detailed break down of population clusters and the regions in which they reside. Because many studies may use these or other definitions, it is difficult to simply refer to areas of residence as rural or urban. As we move forward from this point, it would be prudent to keep this in mind.

In examining the issues confronting these two types of regions, we will explore some of the unique characteristics of both the individuals and the societies which they inhabit. People residing in rural communities face issues that differ from those who live in the cities.

**Demographics**

In 1997, the rural population of the United States reached 54 million; approximately 20% of the Nation's total population. While this growth in the rural population slowed during the period from 1995 to 1997, overall rural population figures still increased. This increase was secondary to a higher number of births than deaths, and indicated a significant migration of the population from urban to rural areas (Beale, 1999). The greatest increase in non-metropolitan population growth was generally in the interior portion of the country.

*Among the nine regions of the country examined by the US Bureau of the Census, the New England region had one of the highest percentages of population residing in metropolitan areas. Despite this fact, the New England Region still had a higher rate of growth within the non-metropolitan areas (Mackun & Wilson, 2000).*

The National Center for Health Statistics reported "…communities at different urbanization levels differ in their demographic, environment, economic, and social characteristics. These characteristics influence the magnitude and types of health problems communities face. In addition, more urban counties tend to have a greater supply of health care providers in relation to population and residents of more rural counties often live farther from health care resources" (Eberhardt et al., 2001).

Some of the other differences between those living in the urban areas and those living in rural areas include the number of elderly residing in rural communities. The 1998 statistics indicate that the percentage of elderly increased 18.4% in rural areas, compared to a 15% increase for urban areas (Rogers, 2000). The growth of the rural older adult population, and the overall inadequacy of rural health care resources, hinders this population's capacity to address their substance abuse needs.

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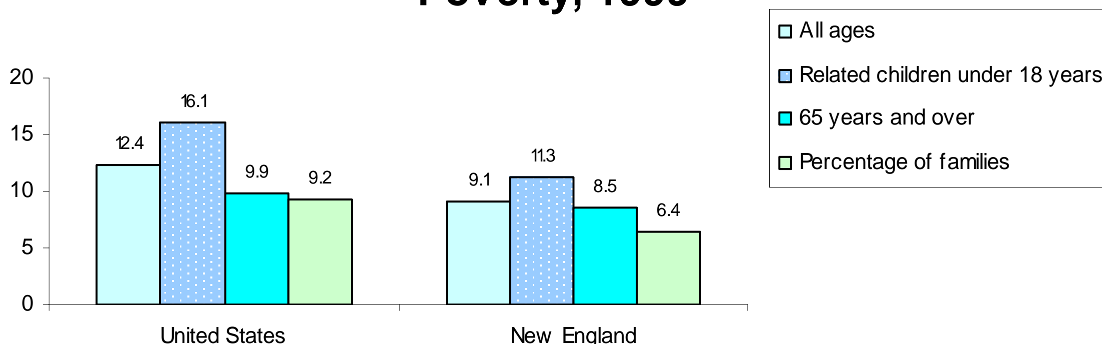
Minorities make up a smaller portion of the rural population. According to the 2000 Census report, Non-Hispanic Whites were 83% of the rural population compared to 67% of urban areas. African Americans were 8% of the rural population while making up 14% of the urban population (US Bureau of the Census, 2001).

Rural communities generally have a greater amount of poverty when compared to urban areas. The 2000 Census reported an urban poverty rate of 10.8% and a rural poverty rate of 13.4%. Poverty impinges upon populations of color at a disproportionate rate. Approximately 7% of White Americans are below the poverty level, while the figures for Blacks and Hispanics were 19.1% and 18.5%, respectively (US Bureau of the Census, 2000). These figures varied across the nation, based upon the migration of population.

*In the northeast, cities have larger increases in poverty when compared to the suburbs. "Poverty rate increases were wide spread, occurring in 13 of 17 central cities, and 18 of 21 suburbs." Providence, Rhode Island was one of the cities with the largest increase in poverty (Berube & Frey, 2002).*

*Despite having pockets of increased poverty, the New England area is below the nation's average for poverty. In 1999, New England's poverty rate for all ages was 9.1% as compared to 12.4% for the nation. This held true for most categories examined by the US Bureau of the Census.*




(See GCT-P14 Income and Poverty in 1999:2000 of US Bureau of the Census, 1999, for complete data)

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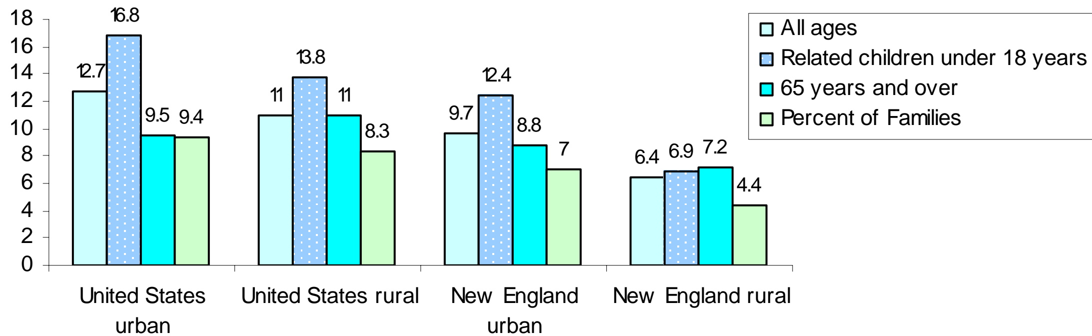


(See GCT-P14 Income and Poverty in 1999:2000 of US Bureau of the Census, 1999, for complete data)

*Urban poverty rates in New England were 9.7% compared to 12.7% nationwide. Rural comparisons were similar***,** *with the nation outpacing New England's rural rate 11.0 percent to 6.4 percent* (US Bureau of the Census, 1999)

Poverty in and of itself does not determine the levels of substance abuse or the need for treatment. Poverty is a formidable barrier to health coverage, resulting in less treatment and preventive healthcare for those in this group. Other economic issues also affect the state of health for the rural population.

## Substance Use in Rural Communities

Rates of substance use, based upon race, gender, and ethnic background of people in rural and urban regions, are similar (Donnermeyer & Park, 1995). One exception to this finding is that of Native Americans. A 1992 study indicated that Native Americans were 5.2 times more likely than the general population to suffer an alcohol related death. Youths on reservations were 3.5 times more likely to have tried marijuana and 8.3 times more likely to have tired heroin (Beauvais, 1998). Current surveys of substance use, based upon ethnicity, show Native Americans and Alaskan Natives to surpass all other ethnic groups in the use of illegal substances.

**Lifetime, Past Year, and Past Month Use of Any Illicit Drug Among Persons Aged 12 or Older by Demographic Characteristics**

| | Lifetime | | Past Year | | Past Month | |
|---|---|---|---|---|---|---|
| | 1999 | 2000 | 1999 | 2000 | 1999 | 2000 |
| White | ***42.0*** | 41.5 | 11.4 | 11.2 | 6.2 | 6.4 |
| Black | 37.7 | 35.5 | 13.2 | 10.9 | 7.5 | 6.4 |
| American Indian or Alaskan Native | ***51.0*** | 53.9 | 18.3 | 19.8 | 10.4 | 12.6 |
| Asians | 20.8 | 18.9 | 6.1 | 5.2 | 3.2 | 2.7 |

(See Results from the 2001 National Household Survey on Drug Abuse: Volume 1, of Substance Abuse and Mental Health Services Administration, 2000, for complete data)

In the past, rural communities were generally considered to be protected from urban substance abuse issues. Now, they are often viewed as a mirror of the urban environment, contrary to the

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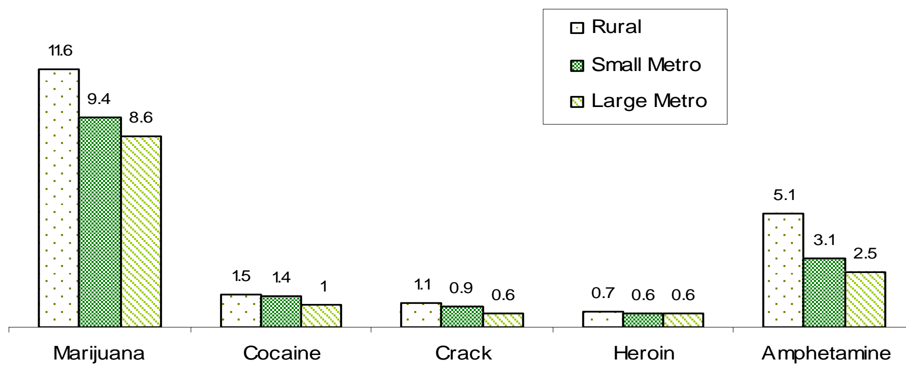
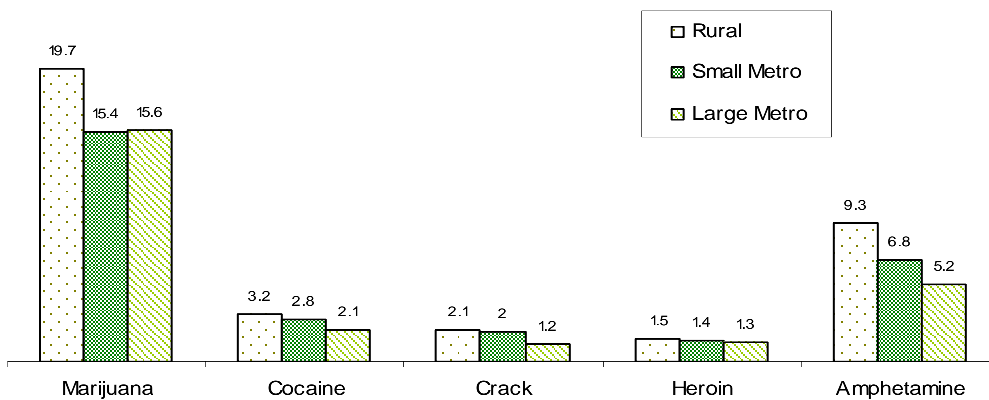
peaceful untouched image of the country community (Beavis, Edwards, Oetting, & Swain, 1986). Recent research indicates that rural areas have matched or exceeded the substance abuse levels found in the non-rural communities. The 1999 Monitoring the Future Study, comparing rural eighth graders with those in large metropolitan areas, showed rural eighth graders were 34% more likely to have used marijuana in the past month and 26% more likely to have used marijuana in the past year. They were also 52% more likely to have used cocaine in the past month and 75% more likely to have used crack (The National Center on Addiction and Substance Abuse (CASA), 2000).

**Past Month Use of Illicit Drugs by Eight Graders: 1999**




(See Monitoring the Future National Survey Results on Drug Use, 1975-1999, of Johnston, O'Malley, & Bachman, 1999, for complete data)

**Annual Use of Illicit Drugs by Eight Graders: 1999**




(See Monitoring the Future National Survey Results on Drug Use, 1975-1999, of Johnston, O'Malley, & Bachman, 1999, for complete data)

Rural 10th graders exceed their metropolitan peers in the use of cocaine and amphetamines. The data also indicated that these same rural students exceed their peers in the use of all drugs except for MDMA (CASA, 2000). These results also held true for those in grade twelve.

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The U.S. Department of Health and Human Services and the Centers for Disease Control and Prevention conducts a yearly survey examining risk behaviors of young people ages 10-24 years and adults 25 years and older. *The 2001 survey indicated the following levels of alcohol and drugs use among the states in the New England region.*

**Alcohol and Other Drug Use, 2001**
**(past month)**

| | Alcohol | Marijuana | Sniffed/Inhaled Intoxicating Substance |
|---|---|---|---|
| United States | 47 | 23.9 | 4.7 |
| Connecticut (1997 data) | 52.6 | 25.8 | 19.1 |
| Maine | 48 | 27 | 13 |
| Massachusetts | 53 | 31 | 12 |
| New Hampshire | 52 | 28 | 15 |
| Rhode Island | 50.3 | 33.2 | 11.8 |
| Vermont | 48 | 30 | 5.3 (1999 data) |

(Source: Centers for Disease Control and Prevention. (2001). Youth 2001 Online-Youth Risk Behavior Surveillance System)

*The results of this survey indicated that each state in the New England region exceeded the national average in every category of measurement for alcohol and other drug abuse. The use of inhalants in the New England region was often double to quadruple the national average.*

*The National Household Survey on Drug Abuse (Substance Abuse and Mental Health Services Administration (SAMHSA), 2001), reported the New England region as having the highest number of youths, 12 years and older, who have consumed alcohol within the past month.* According to this survey, more youths ages 12 to 17, in the rural communities, consumed alcohol in the past month or had heavy use of alcohol. Adults' use of alcohol in large metropolitan areas out paced those in rural communities for past month use. Under the heavy alcohol use category the difference between these two communities were less significant.

Some research is beginning to indicate that the use of alcohol or tobacco may be a precursor to other drug use. According to data from the U. S. Center for Disease Control and Prevention's 1995 Youth Risk Behavior Survey, those who drank and smoked in the past month were 30 times more likely to smoke marijuana. In addition, those youths who used alcohol, tobacco, and marijuana in the past month were more likely to use other drugs in the future (Gfroerer, Wu, & Penne, 2002).

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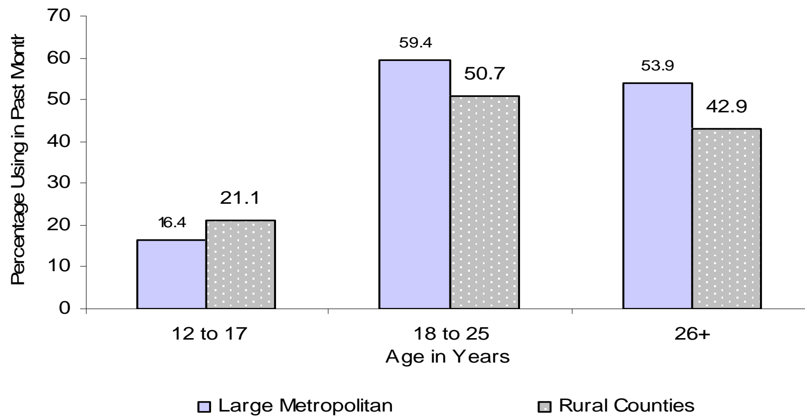
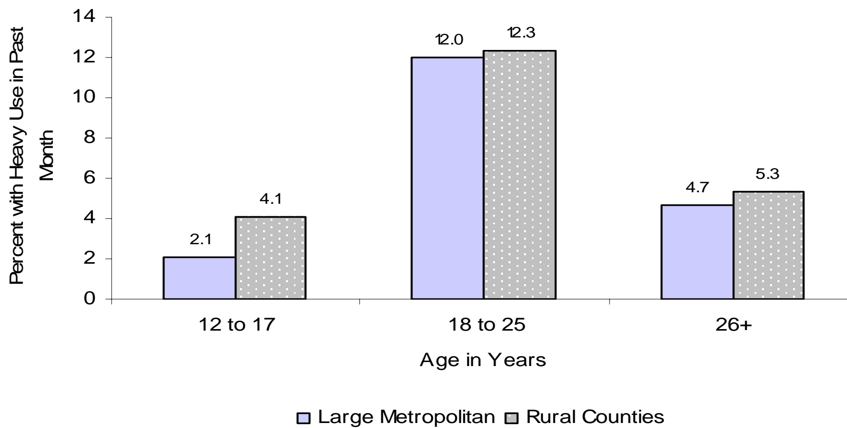



(See Volume I: Summary of National Findings: Alcohol Use, of Substance Abuse and Mental Health Services Administration, 2002, for complete data)




(See Volume I: Summary of National Findings: Alcohol Use, of Substance Abuse and Mental Health Services Administration, 2002, for complete data)

According to the National Household Survey on Drug Abuse (2001), youths 12 and older living in the less densely populated areas used tobacco at a higher rate. This trend reflects the following statistics for percentages smoked in the past month:

| | Percentage |
|---|---|
| Large Metropolitan | 22.9 |
| Small Metropolitan | 26.5 |
| Non-metropolitan | 27.3 |
| Completely Rural Non-metropolitan | 28.5 |

According to the Florida Youth Substance Abuse Survey, rural youths had a lower rate of perceived harm from alcohol, tobacco, and other drug use than those living in urban areas. Some studies indicate an association between smoking and the use of other illegal substances. Shoptaw

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et al. (1996) examined the issue of opiate abusers seeking to stop smoking, and concluded that those who were unable to refrain from smoking were more likely to use cocaine in the future.

## *Effects* of Substance Abuse to the Rural Communities

### Crime

In 1998, rural crime resulted in excess of 800,000 arrests. (US Department of Justice, 1999) Many of these arrests are related to drug abuse. Overall, the rural crime rate fell less than the rate for urban and suburban regions (Bureau of Justice Statistics, 2000). The number of rural violent crime offenders was higher than that for urban and suburban offenders; 39% to 29% respectively. Rural homicides (21%) were more likely to be committed by an intimate offender as compared to 7% for homicides committed in large cities (US Department of Justice, 1999).

Substance abuse, juvenile delinquency, and criminal activity are interrelated. Minor behavioral issues are initiated prior to the abuse of alcohol or other drugs (Elliot, Huizinga, & Menard, 1989). This theory lends support to the family's critical influence on children's antisocial behavior (Loeber & Stouthamer-Loeber, 1986). Thornberry's (1987) view of this parent-child and child-parent influence pointed to a cycle of one action by a child leading to an action by a parent repeating upon itself. These recurring actions escalate the child's conduct from minor to major delinquency. The family provides an important influence on the social development of the child, but there are other social factors as well. Other influences include delinquency, marital status, education, employment status, ethnic background and religion.

### Health Services

The use of illicit substances within rural communities increases the need for more health care services. The lack of health insurance and health services compounds the substance abuse issues faced by those living in rural communities. Figures from the Centers for Disease Control and Prevention indicated that from 1994 to 1998, AIDS cases in rural regions increased by 82% while the urban figure grew by 59%. This fact is of increased concern to the rural community, since rural youth and young adults have a higher rate of intravenous drug use (Centers for Disease Control, 1994). Rural male respondents from the 1997 Youth Risk Behavior Survey indicated that they were more likely to have had sexual intercourse and to not have used a condom (Crosby et al., 2000). This increased risky behavior contributes to the levels of sexually transmitted diseases and HIV/AIDS found with this population. The rural population living with HIV or AIDS creates a greater challenge to service providers because they are dispersed across large regions. *The following data reflects the New England statistics for people with AIDS. These numbers peaked in the early to mid 90's before returning to the current levels.*

**New England AIDS cases reported, by area of residence**
**July 1991 through June 2001**

| | 1991-92 | 1992-93 | 1993-94 | 1994-95 | 1995-96 | 1996-97 | 1997-98 | 1998-99 | 1999-00 | 2000-01 |
|---|---|---|---|---|---|---|---|---|---|---|
| Connecticut | 479 | 1461 | 1306 | 1051 | 1506 | 1195 | 880 | 610 | 639 | 512 |
| Maine | 56 | 77 | 137 | 139 | 80 | 55 | 41 | 42 | 67 | 44 |
| Massachusetts | 852 | 1897 | 2009 | 1358 | 1278 | 1087 | 736 | 1225 | 1487 | 838 |
| New Hampshire | 53 | 89 | 89 | 115 | 99 | 68 | 53 | 51 | 35 | 30 |
| Rhode Island | 121 | 231 | 272 | 283 | 178 | 160 | 133 | 121 | 93 | 106 |
| Vermont | 22 | 26 | 81 | 30 | 40 | 32 | 19 | 16 | 32 | 31 |

(Centers for Disease Control and Prevention. (2001). Table 1)

*The following statistics of student sexual behavior in the New England region raises concern about their health and related substance use.*

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**New England Region Sexual Behavior**

| | Ever had sexual intercourse | Did not use birth control during last intercourse | Sexual intercourse past three months using alcohol or drugs before intercourse |
|---|---|---|---|
| United States | 45.6 | na | 25.6 |
| Connecticut | 43.5 (1997 data) | na | 27.2 (1997 data) |
| Maine | 46 | 64 | 24.6 |
| Massachusetts | 44 | 77 | 22.7 |
| New Hampshire | 39 | 72 | 21.1 |
| Rhode Island | 45.9 | na | 27.3 |
| Vermont | 49.4 (1995 data) | na | 28.0 |

(Source: Centers for Disease Control and Prevention. (2001). Youth 2001 Online-Youth Risk Behavior Surveillance System)

### Drugs in the work place

Along with the overall increase in drug use comes the use of these drugs in the work place. A 1998 report, where five million employees were drug tested from various areas across the country, revealed that the rural regions of Florida, Tennessee and Indiana had between 8% and 14% drug use in the work place as compared to 4% to 6% in the three largest metropolitan areas (CASA, 2000; SmithKline Beecham, 1998).

In 1997, employee*s* who reported current illicit drug use were more likely than those who reported no current illicit drug use to have worked for three or more employers in the past year 9.3% versus 4.3%*;* to have skipped one or more days of work in the past month 12.9% versus 5%, or to have voluntarily left an employer in the past year 24.8% versus. 15.4% (SmithKline Beecham, 1998).

## Rural Myths, Life and Barriers

### Myths

One common myth is that rural life is mainly agricultural and the region is safe and isolated from the problems and issues of the metropolitan areas. The truth is that in 1972, 7.6% of the rural employed worked in the farming industry. Today even in those areas where farming is assuming a greater role, 80% of working people are not employed in the farming industry (US Department of Agriculture, 1995) Another myth is that the vast numbers of poor are African American or Hispanic. The truth is that the majority of people living in poverty**,** in urban and rural areas**,** are white (O'Hare, 1996). These types of myths have existed for many years within the rural communities. Life is no long the slow sedentary pace still portrayed in movies. These types of myths continue to exist and as a result, substance abuse issues do not receive the attention it needs. The community leaders and residents need to be educated on the substance abuse issues they and their family truly face*,* in these times.

### Life

The 2000 U.S. Census reported the national poverty rate for all ages at 12.4%, for related children under the age of 18 years at 16.1%, and 9.9% for those 65 years and older. *The New England region fared better with rates of 9.1%, 11.3%, and 8.5%, respectively. The* States *of Maine and Rhode Island were the two areas with the highest percentage of population below the poverty level (US Bureau of the Census, 1999). Within the New England States, rural regions did not appear to demonstrate increased poverty levels. The 2000 Census reflected rural, urban, metropolitan and non-metropolitan with similar rates in the New England division.*

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Examination of ethnic heritage in rural regions reflects that non-Hispanic Blacks and non-metropolitan Hispanics have the highest level of non-metropolitan poverty, 28% and 27%, respectively. These figures far exceed those of non-Hispanic Whites, at 10.4%.Poverty continued to be an issue with other special population groups, including single-family household, single females, and children living in rural regions (US Department of Agriculture, 2002).

The two-parent family has decreased in both the metropolitan and rural regions. Along with this decrease in two-parent families have come an increase in female-headed homes, women in the workforce and an increase of children born to unmarried or teenage mothers (Bowers & Hamrick, 1997). "More than one out of every three persons living in non-metro families that are headed by a female is poor." Single male households have a poverty rate of one out of five (US Department of Agriculture, 2002).

In 1996, over 33% of the adults living in rural communities were without a high school education and receiving welfare (Cook & Dagata, 1997). Poverty, low levels of education, and changes to the structure of the rural families have enabled those living in these communities to reflect similar substance abuse issues as those living in the more populated areas. Unfortunately, rural communities also find themselves lacking reasonable access to services. These conditions have undermined the health of residents of these communities.

**Barriers**

The limited health care resources available to the rural communities affect the region's ability to address the growing issues around substance abuse. Being sparsely populated is also a barrier to effective substance abuse treatment; requiring people to travel great distances for services. The rural population's problems are further complicated by the shortage of health care personnel in the rural areas. These rural regions have less available services and less medical and substance abuse support personnel (CASA, 2000). For these reason many of those living in these rural areas go undiagnosed or treated for their health problems.

Physicians who work in urban areas make more money and therefore, have less incentive to practice in the rural regions. The growth of specialized medical practices compounds the problem. Health care facilities are reluctant to expend resources for satellite facilities due to limited funding and doubtful return on investment. Federal and State efforts are needed to address this issue.

The lack of public transportation hinders access to services for members of the rural community (Human & Wasem, 1991). Because they live in sparsely populated regions, these residents have a difficult time getting to health care providers for services. Because of the lack of resources, rural communities are limited in their ability to address the issues of substance abuse and its inherent problems. Some of the common issues of substance abuse include increase in crime, less enforcement of drug laws, and numerous health issues such as less health coverage, a greater number of Medicare and Medicaid participants, and less services and personnel for treatment.

The state of being rural, or the lack of population density, contributes to the poor health status of residents in these regions. Health care providers are unable to uncover a solution to provide the same level of health coverage found in metropolitan areas for isolated populations. As a result, members of these rural communities, and clients for treatment services, face a more difficult challenge.

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A shortage of providers leads to a lack of specialized services (SAMHSA, 1997). One example of this is that only 11% of services in the rural community are directed at youth as compared to 15% in urban areas (Condelli, Bonito, Ennett, & Fairbank, 1996). This presents a reality that is vastly different from the old view of rural communities, with strong family ties, dealing with life's simple issues on their own. The rural quality of these communities continues to depreciate, with elevated substance abuse and health related problems.

According to the Health Care Finance Administration (1998), in 1996, 22 million residents of rural areas were living in areas with a shortage of health professionals and were medically underserved. The ratio of people living in the rural communities in the United States is one in five while the ratio of physicians practicing in these areas is one in ten. In 1997, 20% of the nation's populations were living in non-metropolitan communities (Health Care Finance Administration, 1998). Again, the disparity in income between physicians in the rural community and those in metropolitan areas is also a factor.

These factors all contributed to the community's inability to deal with the varying levels of health related issues due to substance abuse. According to the U.S. Department of Health and Human Services (2002), 20 million out of 70 million rural residents have inadequate access to health services. This is compounded by the fact that nearly half of these rural community members also have major chronic illnesses. Figures from the U.S. Centers for Disease Control indicate that from 1994 to 1999, AIDS cases increased 82% in rural communities. This is also reflected by increases in the figures for intravenous drug use by youths living in the rural regions (CASA, 2000). Despite this undisputable need, fewer rural residents see a physician.

One survey indicated that between 10% to 12% of the rural population did not seek health care immediately due to the associated cost. The urban community figures for those not seeking health care, due to cost, was at 8% (Schur & Franco, 1999). In addition, there is wide spread poverty afflicting rural communities. In 1999, 14.3%, of rural residents were at the poverty level, compared to 11.2% in urban areas (US Bureau of Census, 1999). As a result, many children were born into homes that left them at an increased risk for poor health outcomes

"[a] community's health depends not only on the sociodemographic characteristics and risk factors of its residents, but also on their access to use of health care services " (Eberhardt et al., 2001). Another factor affecting health care access is the lack of health insurance and inadequate health insurance coverage. Rural areas have more uninsured or underinsured people then those found in metropolitan areas (Hartley, Quam, & Lurie, 1994). In 1996, there were in excess of 10 million inhabitants in rural areas without insurance. Statistics indicated approximately 19.8% of those in the rural community as uninsured compared to 16.3% in the urban communities. This was also reflected with private insurance where 53.7% of these rural residents had private insurance compared with 62.5% in urban areas (Vistnes & Monheit, 1997).

The lack of health insurance affects the state of health of those living in these regions. Another result of poverty is the inability of members of the communities to afford to pay the full cost of healthcare. These factors all contribute to the lack of access to health care for this population.

The lack of sufficient population to sustain a health care facility and employ physicians also creates barriers for rural residents, who are in need of substance abuse treatment. These conditions come into play when organizations and medical personnel examine the possibility of working within the rural community.

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Recently, the U.S. Department of Health and Human Services awarded $26.7 million in grants to improve health care in rural America. One focus of these grants is to improve the quality of health care services, especially since access is limited. An additional focus is to provide needed equipment and to train emergency personnel.

*While the New England area does not lead the nation with substance abuse in rural regions, similar rural issues continue to exist. The rural communities do have issues due to their social and economic status. The issue of the lack of access to health care services and adequate health care personnel plagues these rural regions.*

Social issues exist and hinder members of the rural community from seeking out substance abuse treatment. Rural families see themselves as being self-sufficient. The inability of members of the rural community to access treatment services compounds their issues around substance abuse. Effective evidence based practices have been developed but due to the low population, many members of the treatment community elect not to work, or offer services, in these rural regions.

## Recommendations

Raising public awareness to overcoming the misconceptions of the rural community is vital to developing a program to combat the issues of substance abuse in rural regions. These regions are no longer a slow paced society, free of violent crimes, gangs and drug use. While these problems are not at the same levels as within urban communities, gangs, drug use and violence have increased. The rural community is no longer the safe haven it was in the past. While their sense of community has been somewhat eroded, there continues to be opportunities to provide strength, and support to the process of addressing substance abuse in rural communities.

Community and government leaders need to be made aware of any erroneous myths and be educated on the substance abuse issues that are occurring within these communities. Efforts can be made to gather the local resources in prevention, education, law enforcement and treatment. Moreover, agencies must collaborate in order to organize and expand these resources, utilizing evidence-based models of practice, resulting in the most effective way to improve the quality of life in rural populations.

We see the growth of the rural regions varying across the country. As a result, the needs in each of these regions also vary. There are differences in poverty, employment, health services, demographics and social structure in these regions. Efforts need to be made to build upon the community's capacity to address substance abuse issues with available resources. The available treatment community resources must be examined to provide adequate levels of services to those locked into the rural community. The failure to pursue this endeavor simply adds to society's failure to remedy substance abuse issues, despite having effective treatment services in existence.

The low density in the population does not encourage a sufficient number of service providers for these regions. Clients are often required to travel a great distance for treatment services. This contributes to the lack of access to health services this population is facing. Specialization in health medicine limits the number of available physicians to practice in the rural regions. Medical schools need to collaborate with rural and academic communities to develop and maintain rural residency programs. Medical personnel also must be offered incentives to practice in these regions. Federal and state assistance is needed to balance the economic differences between urban and rural health services.

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This also holds true for the level of health insurance available to those living in these depressed regions. The lack of health coverage or ability to pay is a serious impediment for this population to access health services for substance abuse issues. Again, federal and state assistance must provide some assistance to support health coverage for individuals living in these rural regions.

Some promising model approaches for addressing the needs of substance abuse treatment in the rural areas can be found in a guide entitled *Bring Excellence To Substance Abuse Services in Rural And Frontier America* (SAMHSA, 1997). *Some of the titles from this collection of award winning papers includes: Drug Use, Sexually Transmitted Diseases, and Sex-Related Risk Behaviors in Alaska, In Rural and Frontier America, It Takes a Whole Community to Habilitate a Substance Abusing Criminal, Continuum of Services for Offenders in South Dakota, Implementing A Family Preservation Services Drug and Alcohol Program in Rural Nevada, Wellness in the Woods-Windsong, Residential Treatment For Mothers and Their Children, Mental Health and Substance Abuse: Challenges in Providing Services to Rural Clients, Community Diversity Issues: Strategies for a Comprehensive Multicultural Framework, A group Intervention Project for Eight Rural Mothers In a Tragic Dance With Alcohol and several others.* These papers focused on some of the special challenges and barriers faced by those working in the various areas of health services within rural communities. These models provide guidance for developing strategies and policies for the delivery of services, program management, needs assessment, community partnerships and successful treatment approaches.

One of the papers**,** by Boyd D. Sharp et al. (SAMHSA, 1997) entitled *In Rural and Frontier America, It Takes a Whole Community To Habilitate A Substance Abusing Criminal***,** examines the treatment obstacles of service delivery in rural communities for the criminal justice offender. The program observed in Oregon addressed the barrier between substance abuse treatment providers and those working in the criminal justice system. To overcome this obstacle a drug court and jail program was developed in this town. The second part of the paper covers the program's treatment model utilizing a cognitive approach through an intensive, outpatient therapeutic community. The effectiveness of this approach is presented with the evaluation of the project found in the remaining part of this paper. The model produced a remarkable 88% reduction in arrest of clients in the program for nine months or more.

No one model exists to address all of the issues surrounding rural substance abuse treatment. The best model would examine the social-demographic characteristics, risk factors, poverty and access to services faced by the specific region. Community support along with Federal and State assistance is also required to develop a successful program for rural communities.

In conclusion the ATTC-NE will seek to take the information gathered to each of the New England single state agencies, in an effort to begin the development of recommendations for addressing some of the substance abuse issues within their rural communities. It has always been and continues to be the ATTC-NE's goal to assist in enhancing substance abuse treatment capacity of local and regional health service providers, that are faced with the unique challenges of their general or special population.

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